



## Teen Volunteer Program Application Process Overview

The minimum requirements for becoming a Teen Volunteer with Hospice & Palliative Care Charlotte Region vary depending on the volunteer job desired. Age requirements, training, and educational history are specified for each volunteer position.

1. Applicant contacts the Volunteer Services Department (704-335-3578) to obtain a volunteer application or downloads an application from our website.
2. Applicant can return completed application to:

**Hospice & Palliative Care Charlotte Region  
1420 East Seventh St.  
Charlotte, NC 28204**

3. After all required paperwork is received; the Teen Volunteer Coordinator will contact the applicant to arrange a convenient time to conduct a personal interview.
4. Teen Volunteer Applicant is notified concerning their acceptance into a Teen Volunteer position. Completed applications do not guarantee placement in a volunteer position.
5. All accepted applicants must complete the following requirements.
  - ◆ ***Family Support Training***, intensive 12-hour training required for direct patient/family teen volunteers.
  - ◆ ***Teens must be 15 ½ to 18 years of age or sophomore, junior or senior in H.S.***
  - ◆ ***Complete reference checks and (2) tuberculosis screenings.***
  - ◆ ***Additional training*** may be required depending on the position filled.
6. Following hospice training, volunteers may be asked to participate in a follow-up training at assigned facility to ensure that volunteer has full knowledge of the facility's safety procedures.



# Teen Volunteer Program Application

## Personal Information

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Name of Parent(s) or Guardians(s): \_\_\_\_\_  
 (Please Print)

Have you experienced a death in the family within the past year?  Yes  No

## Emergency Contact Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Family Physician: \_\_\_\_\_

## Volunteer History

Organization	From (Mo/Yr)	To (Mo/Yr)	Position/Description of Role

## Employment Experience

Name of Employer	From (Mo/Yr)	To (Mo/Yr)	Position/Description of Role

## Areas of Service

**Please identify areas of service that interest you (check all that apply).**

TLC Team  Office Support  Special Events

Other (Describe): \_\_\_\_\_

## Skills and Abilities

Please identify all skills and abilities that apply. Also note any special skills and knowledge that might be pertinent for the volunteer position desired.

### Computer Skills (check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Databases           | <input type="checkbox"/> Spreadsheets        | <input type="checkbox"/> Word Processing   |
| <input type="checkbox"/> Power Point         | <input type="checkbox"/> Website Design      | <input type="checkbox"/> Graphics Software |
| <input type="checkbox"/> Publishing Software | <input type="checkbox"/> Multimedia Programs |  |

Any additional computer knowledge/skills: \_\_\_\_\_

### Office Skills (check all that apply):

- |                                      |   |                                    |
|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Fax Machine | <input type="checkbox"/> Copier             | <input type="checkbox"/> Telephone |
| <input type="checkbox"/> Calculator  | <input type="checkbox"/> Laminating Machine |                                    |

Any additional office skills: \_\_\_\_\_

### Additional Skills and Talents (i.e., theatrical skills, photography, artistic ability, hobbies/crafts, etc.):

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## Essay Questions

These questions are designed to help determine the best fit for you in our organization. Please attach short responses (two paragraphs or less) on the back to the following questions.

1. Describe a previous volunteer experience that you have held. Did it involve a leadership role? What did you like most and least about the experience?
2. Why do you want to be a Hospice & Palliative Care Charlotte Region Teen Volunteer?

## Signatures and Authorization

Hospice & Palliative Care Charlotte Region is not obligated to provide a placement, nor are you obligated to accept a position offered. Opportunities for volunteers are provided without regard to race, religion, gender, ethnic origin, disability, age, or sexual orientation.

I understand that all volunteers represent Hospice & Palliative Care Charlotte Region and are subject to the rules, and regulations of the organization. I authorize Hospice & Palliative Care Charlotte Region to acquire additional information from references attached to this application, and I hereby release them, their companies and Hospice & Palliative Care Charlotte Region from any liability whatsoever concerning information obtained through this application.

The information provided has been completed thoroughly and truthfully by the Teen Volunteer Program applicant. This application and any other documents obtained during the application process will remain confidential in the Hospice & Palliative Care Charlotte Region Volunteer Services Office.

Teen Applicant Name (Print): \_\_\_\_\_

Teen Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Tuberculosis (TB) Testing Consent

All new teen volunteers with Hospice & Palliative Care Charlotte Region must be administered two TB tests prior to working with patients. These tests are available at no charge. The first test is administered during volunteer training with results evaluated on the second day following the test. The second test is administered two weeks after the first. Your signature below authorizes Hospice & Palliative Care Charlotte Region to administer the required TB Screening for your teen.

Hospice & Palliative Care Charlotte Region has my permission to administer required TB Screening for my child.

Parent/Guardian Name (Print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Publicity Release

At times, information concerning a volunteer may be used in a press release, for fundraising purposes, or other reasons deemed appropriate by Hospice & Palliative Care Charlotte Region. Submission of this application provides consent for Hospice & Palliative Care Charlotte Region to use the teen volunteer's name, title, portrait, picture, video image, photograph, or any reproduction likeness or quotation of the teen volunteer's remarks for public information, fundraising purposes, or other organizational programs as approved by Hospice & Palliative Care Charlotte Region.

## Parent / Guardian Acknowledgement

Please read the following statements with your teen volunteer applicant and sign below:

- Teens under 18 years old are not allowed to transport patients or their family members by auto.
- Universal Precautions taken by medical personnel when working with all patients and Infection Control are taught during volunteer training.
- All patient information is confidential. Since your child may share information with you concerning their volunteer experience, your signature below indicates that you will keep in confidence any information shared with you about a Hospice & Palliative Care Charlotte Region patient.
- All Teen Volunteers must document each visit with patient/family. This documentation becomes part of the medical record which is an integral part of the Hospice & Palliative Care Charlotte Region plan of care for the patient and facilitates government funding.

Parent/Guardian Name (Print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## References

Please provide the name, complete address and relationship of two professional or personal references who are not related to you.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Statistical Information (optional)**

**This information is only used in conjunction with grant requests for further funding for Hospice & Palliative Care Charlotte Region**

- |                    |  |   |
|--------------------|--|---|
| Gender:            | <input type="checkbox"/> Male                      | <input type="checkbox"/> Female             |
| Ethnic Background: | <input type="checkbox"/> Caucasian                 | <input type="checkbox"/> Hispanic or Latino |
|                    | <input type="checkbox"/> Black or African/American | <input type="checkbox"/> American Indian    |
|                    | <input type="checkbox"/> Other                     |   |